PROCEDURE

Oral Health Assessment

Scope (Staff):	Community health
Scope (Area):	CACH, WACHS

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this disclaimer

Aim

To assess oral health and identify early childhood caries and oral disease, and to educate parents/carers to maintain and monitor their child's oral health.

Risk

Failure to prevent and identify early childhood caries can have an impact on: [1, 2]

- An individual level – causing pain and discomfort, difficulty eating, and poor nutrition, and affecting sleep, speech, self-esteem, and quality of life.
- Health systems and society – higher cost of treating advanced disease and impact on systemic health associated with chronic infection.

Background

The impact of poor oral health is wide ranging. Poor oral health is the third highest cause of preventable hospital admissions in Australia.[1] It can impact general health and wellbeing, and psychological and social wellbeing. The World Dental Association defines oral health as "…multifaceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort, and disease of the craniofacial complex".[3]

The most common oral diseases are dental decay (or caries) and gum disease (gingivitis).[4] Caries that occur in children younger than 72 months are called early childhood caries (ECC). [5] Around four in ten (40.3%) children aged 5-10 in Western Australia experience dental decay. On average children aged 5-10 in Western

Australia have 1.4 teeth missing or filled due to caries.[6, 7] Preventing tooth decay in childhood is easier and less costly than treating it.[4]

ECC is a multifactorial disease that involves local factors such as bacteria and dietary sugars as well as psychosocial determinants such as health literacy.[8] Gingivitis can also occur in childhood and is an inflammation of the gums primarily due to plaque and bacteria accumulation on the teeth developing over time.[8] ECC can occur as soon as the first tooth erupts (around 6 months) and is commonly found on the upper front teeth, but other teeth may be affected.[9]

ECC can impact a child's function including their ability to chew (which can impact nutrition), speech development, dental spacing and aesthetics.[10] Good oral health in childhood is an important part of general health and wellbeing and contributes to good oral health in adulthood.[11] Primary teeth are important as they help develop eating ability, speech patterns and appearance as well as guiding the eruption and position of permanent teeth.[11]

The behaviours that are developed during early childhood such as daily toothbrushing and healthy eating and drinking habits can prevent problems with oral health and disease across a child's lifespan.[12] Parents can help prevent or reduce decay risk in themselves and their children by role modelling good oral hygiene and dietary practices. A positive early exposure to oral health assessments can detect early signs of ECC, help reduce children developing fears of dental procedures and dental practitioners and lead to better oral health outcomes.[2, 13]

A regular oral health assessment using the technique known as "Lifting the lip" (to assess the teeth, tongue, lips, cheeks, and gums) to check for early signs of ECC has been shown to have significant benefits for young children.[11, 14, 15] The Australian oral health monitoring group, recommends that all children should have an oral health risk assessment ideally as soon as their first teeth appear, and no later than two years and be referred to a dental practitioner as required.[1] Parents/caregivers should also be encouraged to perform an oral health assessment on their child at home at least monthly to check for early signs of ECC.[14] The earlier decay is detected the better the outcomes will be for the child.[14]

Risk factors:[1, 2, 15]

- Biological determinants: shape (molars with deep pits and grooves) and contact points between teeth, family history of caries or extraction (especially maternal), prematurity or developmental disabilities and disorders.
- Socio-economic factors: access to dental services, health literacy and education.
- Behavioural: consumption of high levels of sugar (particularly sweet foods that stick to the teeth), oral health behaviours, infant feeding choice and eating habits (frequent snacking) and toothbrushing habits.
- Environmental: lack of fluoride exposure.

Some groups have been found to have a higher risk of poor oral health.[1, 10, 16, 17], children with special health care needs (up to 3 times higher), people on low incomes

(1.5-1.7 times higher), Aboriginal people (1.5 times higher), regional, remote, and very remote residents (1.4 times higher) and culturally and linguistically diverse people (1.2 times higher).

Key points

- Oral health assessments by lifting the lip and encouraging mouth opening are recommended during the Universal 12 month , 2 year, and School Entry Health Assessment contacts.
- If a concern is raised by a parent/caregiver, teacher, or health professional targeted assessment should be offered to children aged 6 months and older (after first tooth erupts).
- When children are already receiving specialist care for existing conditions such as cleft lip and palate, it is not necessary to complete the oral assessment. Parents/ caregivers should still receive the health education component and resources.
- Nurses deliver oral health education messages and promote good oral health practices for the whole family whenever possible.
- Ensure family-centred and strengths-based approaches are used, for a shared understanding of concerns and care planning that is proportionate to client needs.
- Oral health assessments are to be conducted by community health staff with appropriate training and assessment skills.
- All nurses will refer to the Nursing and Midwifery Board AHPRA Decision-making framework in relation to scope of practice and delegation of care to ensure that decision-making is consistent, safe, person-centred and evidence-based.
- Nurses need to provide a culturally safe service delivery which demonstrates a welcoming environment that recognises the importance of cultural beliefs and practices of all clients.
- Community health nurses must follow the organisation's overarching CAHS Infection Control Policies or WACHS Infection Prevention and Control Policy and perform hand hygiene in accordance with WA Health guidelines at all appropriate stages of the procedure.

Equipment

- Chair for parent/caregiver (in child health setting) and nurse.
- Disposable latex free gloves (for use as per standard precautions).
- Penlight torch (if required).
- Alcohol-based hand rub.

- Detergent-disinfectant wipes (e.g., Clinell wipes).
- Tissues (for wiping teeth if required).

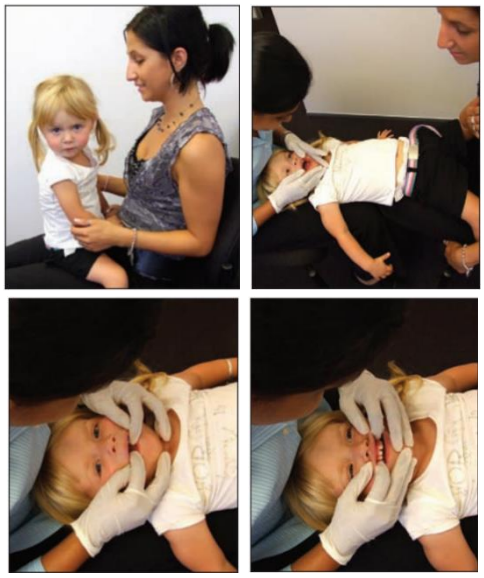
All equipment must be cleaned before and after each use:

- CACH see *Medical Devices: Single Use, Single Patient Use and Reusable,*
- WACHS see *Infection Prevention and Control Policy*

Procedure

Steps	Additional Information
1. Engagement and consent • Identify the child as per Patient/Client Identification Protocol (CACH) or Patient Identification Policy (WACHS). • Encourage parent/caregiver to support and be involved with the procedure where appropriate. • Explain the procedure to the child and parent/caregiver if present. Where this includes a digital examination by the nurse this must be explained. Allow sufficient time for discussion of concerns. **Child Health:** • Obtain verbal parental consent prior to proceeding with assessment. **School Health:** • Ensure written consent has been obtained prior to proceeding with assessment as per *CHS409-1 SEHA parent questionnaire.* **Targeted assessments:** • Obtain consent as per consent policy documents; where verbal consent is obtained it must be documented in detail in the client record.	• Consent should always be informed, current and relevant to the treatment in accordance with CACH Consent for Services Policy or WACHS Engagement Procedure. • Section 337(1) of the *Health (Miscellaneous Provisions) Act 1911* authorises nurses specified in the schedule to assess a child without parent/caregiver consent if required. In this case Consultation with the Clinical Nurse Manager must occur prior to assessment, the school principal or delegate to be advised as appropriate.
2. Prepare the child. • Perform hand hygiene and don PPE (where appropriate).	• Standard precautions are to be applied by all staff, for all clients and at all times when conducting

Steps	Additional Information

• If there is evidence of food in the mouth:
  ○ Child Health - encourage parents to wipe their child's teeth (with bib or soft cloth)
  ○ School Health - encourage child to wipe their own teeth with a tissue.
• Position the child appropriately so that the oral health assessment can be performed.
Birth to three years of age:
• Child sits on the parent/caregiver's lap, facing the parent/caregiver.
• Parent/caregiver leans the child back, so the child's head is resting on the parents/ caregivers' lap.
• Ask parent/caregiver to lift the child's lip so the nurse can look inside the mouth. Alternatively with gloved hands, the nurse lifts the child's lip.
• Encourage child to open their mouth so the front and back of the upper front teeth and then the entire mouth can be assessed.
• Remove gloves (if applicable) and perform hand hygiene.
Children over three years:
• Sit in a chair and with child in front, facing the nurse.
• Ask child to lift their lip. Nurse may assist child to lift their lip (with gloved hands).
• Ask the child to open their mouth so that nurse can look in the oral cavity and observe for any other concerns.
• Remove gloves (if applicable) and perform hand hygiene.
	assessment and/or in contact (or likely to be in contact) with blood or body fluids, non-intact skin and mucous membranes.
	• Nurses should wear gloves if there is a potential risk of exposure with client's blood/body fluids or contact with non-intact skin or mucous membrane.
	• When performing the assessment, examiner considers own posture to minimise any risk of musculoskeletal injuries.
	Birth to three years:[15]
	 
	• Encourage the parent/caregiver to lift their child's lip to facilitate them feeling comfortable and confident performing "lift the lip" at home.
	• It is important to support the head of the child to ensure safe, secure, and successful screening.[15]

Steps	Additional Information
	Children over three years:[11]   • Use a penlight torch to illuminate the teeth if needed. [11]
3. Conduct assessment • Examine: ○ Mouth ○ Teeth ○ Tongue ○ Cheeks ○ Lips ○ Gums For information on assessing oral anatomy for functional and anatomical concerns see Physical Assessment 0-4.	**When performing assessment note the following:** • Mouth – general health, symmetry, moisture level, general integrity, odour, and pain. • Teeth – number, colour (neck of tooth and gumline), decolourisation (brown and white patches), and cavities. • Tongue, cheeks, lips, and gums – lumps, sores, decolourisation, ulceration, significant textural variations, smell, or abscesses. Refer to Physical Assessment 0-4 for additional information.
4. Interpret results[11, 12, 18] **Healthy mouth:** • Teeth should have a whitish hue, be smooth and glossy, (except for the biting surfaces of the molar teeth, which will be grooved), plaque and food debris free. • Gums are firm, and moist not puffy or bleeding. • Mucous membranes that line lip, cheeks, palate, and underside of tongue should be smooth, glistening, uniform and moist. • Free from ulcers, lumps, or sores.	• See Appendix A: Oral Health Assessment Guide for images to guide assessment of tooth decay. • For tooth eruption and development ages see Physical Assessment 0-4 • In children with darker skin, gums are more deeply coloured and a brownish area is often observed along the gum line.[11] • Nurses should be aware that child neglect or maltreatment can manifest in issues in the oral cavity.[19] ○ Dental Caries: when there is evidence of a persistent

Steps	Additional Information
Early signs of decay: • Excessive plaque. • Swelling of gums. • White spot lesions **Advanced sign of decay:** • Brown and yellow spots (that don't brush off). • Very red and inflamed gums. • Cavities (decay). • Ulcers, lumps, and sores.	failure to meet a child's basic oral health needs.20 ○ Trauma: May include contusions, bruising, burns, lacerations of the tongue, lips and buccal mucosa, palate, gingiva, frenulum, or fractured teeth. ○ Sexual abuse: may be indicated by an unexplained injury or petechiae of the palate, especially at the junction of the hard and soft palate. Concerns should prompt further investigation and discussion with Line Manager and Child Protection Unit (see CACH – Child Safety and Protection Policy or WACHS – Guidelines for Protecting Children 2020).
5. Communicate results with parents/caregiver. **If healthy mouth:** • Discuss results with parent/caregiver (if present) or inform by telephone only if requested on CHS409-1 SEHA parent questionnaire. **If early or advanced signs of decay:** • Child health: the parent/caregiver should be informed. • School Health: Contact parent/caregiver to discuss findings and need for referral.	• Refer to Language Services policy for information on accessing interpreters. • Use oral health education materials that are best suited to meet the needs of clients.[18] Resources in different formats and languages are available from the Useful external resources section. • If unable to contact a parent/caregiver to discuss a concern, follow CACH or WACHS processes to provide effective communication with the family.
6. Provide Education • Provide age-appropriate education around oral hygiene practices and nutrition (regardless of results of oral health assessment) as per Appendix B: Oral Health Education for Parents/Caregivers.	**Child health refer parents to** Your child magazines: • Your toddler magazine 1-2 years. • Your child magazine 2-4 years. **School Health refer parents to:**

Steps	Additional Information
	• Tips to support healthy choices (2 to 5 years) (Healthy Teeth section). • This item has been prepared for use in school newsletter: Dental Health. • For additional resources see Useful external resources (including resources in other languages, and resources for Aboriginal families).
7. Refer and follow up. Discuss referral with parents/caregivers to offer information and support: **Healthy mouth:** • Under 18 months recommend dentist visit before 2 years. • Over 18 months: recommend dentist visit within 6 months. **Early signs of decay:** • Recommend dentist visit within 2-3 weeks. **Advanced sign of decay:** • Recommend immediate dentist follow up. Complete CHS663 Clinical Handover/Referral form for dental professional assessment. Refer to Clinical Handover – Nursing for more information. For clients at risk follow up must occur with parents/caregivers to determine if the referral has been actioned. This includes clients of concern, children in care, or those with urgent oral health concerns. • For other clients, use clinical judgment to determine if referral has been actioned. Document plan for referral and follow up in CDIS or CHIS.	**Referral options include:** • Dental Health Services. • School Dental Services. • Private general dentist. • Specialist paediatric dentist. • Oral Health Centre of Western Australia. • Perth Childrens Hospital or local hospital (if signs of significant/spreading infection). • Smiling Starts Early Childhood Dental Program (selected areas). For more information see: Oral Health Assessment Referral Options **Dental Subsidy Scheme:** • The Childhood Dental Benefits scheme is a program for children aged 0-17 who are eligible for Medicare and receive a relevant Australian government payment. For more information see Useful external resources.

Steps	Additional Information
8. Document • Community health nurses working in child or school health settings will document relevant findings in the electronic record (CDIS or CHIS). ○ CDIS users should indicate any concerns or lack thereof using the “lift the lip” prompt, noting any colour changes. Document significant findings, discussion topics, or advice given in the clinical notes.	Complete School Entry Health Assessment Results for parents (CHS409-6) and School Entry Health Assessment Results for staff (CHS409-2), as relevant.

Documentation

Nurses maintain accurate, comprehensive, and contemporaneous documentation of assessments, planning, decision making and evaluations according to CACH and WACHS processes.

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https://www.bda.org/news-and-opinion/news/dentists-call-for-sweeping-action-on-baby-pouches/.

Related internal policies, procedures, and guidelines
The following documents can be accessed in the CACH Clinical Nursing Policy Manual HealthPoint link or CACH Clinical Nursing Policy Internet link
Nutrition Birth to 18 years
Physical Assessment 0-4
Universal Contact 12 months, 2 years, School Entry Health Assessment
The following documents can be accessed in the WACHS Policy Manual
Consent for sharing information: Child 0-17 years
Enhanced Child Health Schedule Guideline
Hand Hygiene
Infection Prevention Control
Health Record Management
Management of Medical Equipment
Patient Identification
Work Health and Safety Policy
The following documents can be accessed in the CAHS Policy Manual
Patient/Client identification
Work Health and Safety
The following documents can be accessed in the CACH Operational Policy Manual
CDIS Client Health Record Management
Client Identification
Consent for Services
The following documents can be accessed in the CAHS Infection Control Policy
Hand Hygiene
Medical Devices: Single Use, Single Patient Use and Reusable

Standard and transmission based precautions

Useful internal resources (including related forms) *(if required)*
Clinical handover/Referral
Referral to Community Health Nurse
CHS409-6A SEHA Results for parents
CHS409-1 SEHA Parent Questionnaire
CHS409-2 SEHA Results for staff

Useful external resources (including related forms)
Advice for Aboriginal people
Child Dentist Benefit Schedule (flier for parents)
Guide to the Child Dental Benefits Schedule
Dental health promotion material from Dental Health Services
Advice for multicultural communities
Raising Children Network: Brushing children's teeth: in pictures, Dental care for babies, Teeth-grinding or bruxism:1-8 years, Toddler teeth issues, Dental care for toddlers, Dental care for newborns, Dental care for pre-schoolers, Pre-schooler teeth issues, Bad breath, Tooth decay, Dentist , Weaning off the bottle, Gingivitis and gum disease, Looking after kids teeth (Aboriginal families)
Smiling Starts Early Childhood Dental Program

This document can be made available in alternative formats on request.

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Standards Applicable:	NSQHS Standards:  Child Safe Standards: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10		

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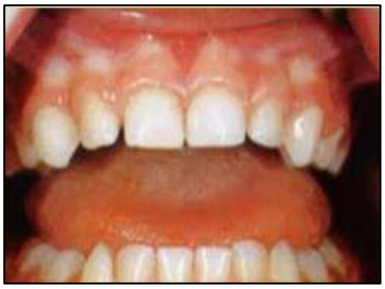
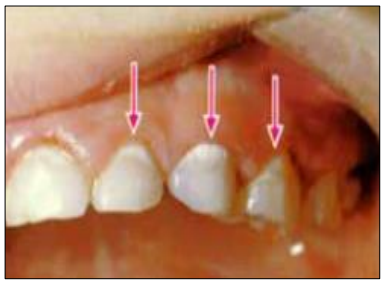
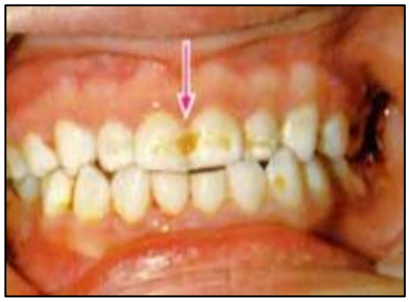
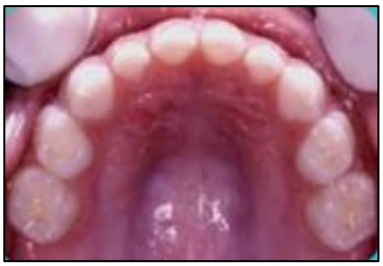
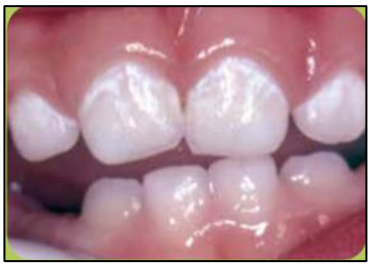
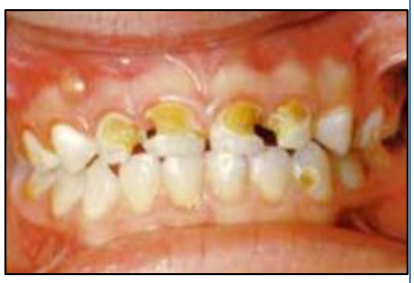
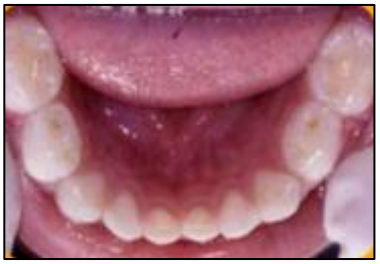
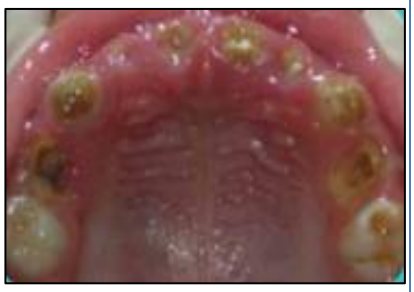
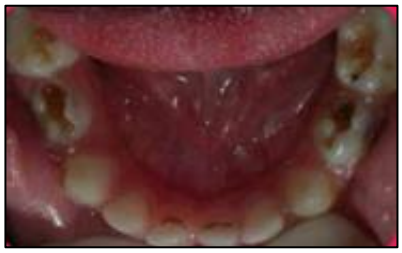
Healthy kids, healthy communities

Compassion | Excellence | Collaboration | Accountability | Equity | Respect

Neonatology | Community Health | Mental Health | Perth Children's Hospital

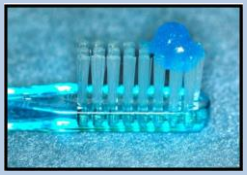
Appendix A: Oral Health Assessment Guide

Table 1: Oral Health Assessment Guide.[2, 12]

Healthy mouth:	Early Sign of Decay:	Advanced sings of Decay:
		
		
		
		

Appendix B: Oral Health Education for Parents/Caregivers

Table 2 2: Oral Health Education for Parents/Caregivers

<table>
<tr><th></th><th>0-18 months</th><th>18 months – 6 years</th><th>6 years and above</th></tr>
<tr><td rowspan="2">Oral Hygiene</td><td>Before teeth appear, wipe gums after feeds using a damp cloth.[12]
When teeth appear, use a soft toothbrush, no toothpaste (just water).[12]
Avoid bacterial transfer (i.e., don’t put anything in baby’s mouth that has been in your mouth).[11]
If a child is using a dummy, do not dip the dummy in any substance. [11]</td><td>Use a small smear (small pea sized) amount of low fluoride children’s toothpaste to brush teeth[2, 15, 21].  Brush teeth morning and night.[15]
Use age-appropriate toothpaste, unless recommended by oral health practitioner.</td><td>Use a pea sized amount of standard fluoride toothpaste to brush teeth.[2, 15, 21]  Encourage children to brush their teeth morning and night with adult assistance (until the age of 8 or 9 years old).[15]
Use age-appropriate toothpaste, unless recommended by oral health practitioner.</td></tr>
<tr><td colspan="3">Brush ‘every bit of every tooth’ in the morning and always before bed at night. It should take about two minutes.[12]
Spit out, don’t rinse after brushing teeth as fluoride in toothpaste helps protect against the development of plaque.[15]
Use an age appropriate toothbrush with soft bristles.[15]
Make toothbrushing positive by being a role model and having a fun time together.[12]
It may be easier to stand behind your child and tilt their head back as you brush or lie the child’s head on your lap to brush teeth.[15]
Everyone in the family should have their own age appropriate toothbrush.[12]
Replace toothbrushes every 3 to 4 months, or earlier if bristles are frayed.[12]</td></tr>
</table>

	• Electric toothbrushes can be beneficial for children with special needs or motor disabilities and are recommended by manufacturers from 3 years of age. Consult with a dental practitioner for individual advice.
Nutrition **(All ages)**	• Encourage healthy eating habits in children and young people.[15] • Encourage children to choose water as their preferred drink. (Do not give fruit juice, cordial, soft drinks, or flavoured milks).[15] • Limit sugary foods and drinks.[6] • Reduce intake of sugar (sweetened beverages, juice, sweets, and processed foods) and watch for hidden sugars in snacks foods (such as foods that have glucose, sucrose, corn syrup and malt extract on the label).[15] • Do not add sweeteners and flavourings to infant formula or other drinks.[15] • Ask for sugar free medicine. • Discourage food pouches as they often have high levels of sugar and often spend more time in contact with the teeth because they are sucked.[22] • Introduce a cup for baby to drink from at 6 months (Encourage giving up the bottle by 12 months).[6] • Breastfeed or feed baby and then put them to bed without a bottle.[15]
General Education **(All ages)**	• Encourage first dental visit no later than two years of age and then regular check-ups.[6] • Primary teeth are important as they help develop eating ability, speech patterns and appearance as well as guiding the eruption and position of permanent teeth.[11] • The earlier decay is detected the better the outcomes will be for the child. • Check for signs of decay every month using “lift the lip” technique.[15]